PRINTED: 01/13/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 000 **Initial Comment** D 000 Surveyor: 25375 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. This Statement of Deficiencies was generated as a result of the State Licensure survey conducted at your facility on 12/30/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 32 residential program beds for the treatment of abuse of alcohol and

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This is a repeat deficiency from the State Licenure survey conducted on 7/23/08.

drugs. The census at the time of the survey was fifteen. Fifteen resident files and thirteen employee files were reviewed. One discharged

9. A personnel record must be maintained for each employee. The record must contain:(c) Reference investigation records

This Regulation is not met as evidenced by:

Based on record review on 12/30/09, the facility failed to conduct a reference investigation on 10 of 13 employees (Employee #1, #2, #3, #4, #5,

resident file was reviewed.

Surveyor: 25375

#6, #8, #11, #12 and #13).

Severity: 1 Scope: 3

NAC 449.114(9)(c) Employees

D 091

SS=C

D 091

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 100 NAC 449.117 Physical Examinations D 100 All persons employed in a facility must have documentation showing that they are in compliance with any applicable provisions of chapter 441A of NAC concerning tuberculosis. This Regulation is not met as evidenced by: Surveyor: 25375 NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. (NRS 441A.120) 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have

a:

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX** CARSON CITY, NV 89701 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 100 Continued From page 2 D 100 (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter. unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and

Prevention as adopted by reference in paragraph

PRINTED: 01/13/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 100 Continued From page 3 D 100 (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by Bd. of Health, eff. 1-24-92; A by R084-06, 7-14-2006) Based on record review on 12/30/09, the facility did not ensure that 4 of 13 employees met the requirements of NAC 441A.375 concerning tuberculosis (Employee #6, #8, #11 and #13). This is a repeat deficiency from the State Licenure survey conducted on 7/23/08. Severity: 2 Scope: 3 D 103 D 103 NAC 449.1214 Social Model Detox Pro SS=D 1. A facility that offers a social model detoxification program: (a) Must have a physician, nurse practitioner, registered nurse or physician assistant conduct a

physical assessment and a review of the general medical and drug history of a client within 24 hours after the client is admitted to the facility to ensure that a social model detoxification program

(b) Must not provide detoxification services for clients who exhibit life-threatening symptoms

is appropriate for the client.

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 103 Continued From page 4 D 103 of withdrawal from alcohol and drug abuse. (c) Must develop and implement policies and procedures that protect the safety and health of clients. The facility must have these policies and procedures reviewed annually by a licensed physician who is familiar with the symptoms of withdrawal from alcohol and drug abuse. (d) ust ensure that the observation of a client during his treatment in the social model detoxification program is reflected in the records of the client as deemed necessary by the policies and procedures of that facility. 2. The staff of a facility that offers a social model detoxification program must complete at least 6 hours of additional education in the detoxification of alcohol and drug abusers, as approved by the program of ongoing quality improvement pursuant to NAC 449.1218, every 2 years. Such education must include instruction in: (a) Acute withdrawal symptoms from alcohol and drug abuse; and (b) First-aid procedures for clients with seizures. This Regulation is not met as evidenced by: Surveyor: 25375 Based on record review and interview on 12/30/09, the facility failed to ensure 3 of 15 client file contained a physical assessment conducted by a physician, nurse practitioner, registered nurse or physician's assistant within 24 hours of admission to the social model detoxification program (Client #3, #4 and #8). This is a repeat deficiency from the State Licenure survey conducted on 7/23/08.

Bureau of Health Care Quality and Compliance

AND DUAN OF CODDECTION 1 '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI	1			(X3) DATE SURVEY COMPLETED			
NVN2ADA				B. WING		12/30	0/2009		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE				
COMMUNITY COUNSELING CTR DETOX			900 EAST LONG STREET CARSON CITY, NV 89701						
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR I	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE			
D 103	Continued From page 5			D 103					
	Severity: 2 Scope:								
D 106 SS=F	NAC 449.123(2) Sanitary Requirements			D 106					
	2. A facility which provides dietary services must have food service equipment of appropriate quality and type for the type of food service program used by the facility. The equipment must comply with all applicable provisions in chapter 446 of NAC.								
	Surveyor: 25375 Based on observation was not using comme appliances per NAC o stove/oven, three mice	chapter 446 (dishmachi	ne,						
	This was a repeat def safety inspection date	ficiency from a previous ed 12/9/08.	s food						
	Severity: 1 Scope: 3	3							
D 130 SS=D	NAC 449.129(1) Construction Standards			D 130					
	equipped and maintain protects the health are	lesigned, constructed, ined in a manner that nd safety of the clients a ty and members of the	and						
	Surveyor: 20773 Based on observation	ot met as evidenced by: n on 12/30/09, the facilification facility by not replacing	ty						

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVN2ADA 12/30/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COMMUN	ITY COUNSELING CTR DETOX	900 EAST LONG STREET CARSON CITY, NV 89701					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
D 130	Continued From page 6		D 130				
	stained ceiling tiles outside room #205 and inside room #209 and room #212.						
	Severity: 2 Scope: 1						
D 216 SS=F	NAC 449.141(8) Health Services		D 216				
	8. Clients of residential programs must unde tuberculin skin test that meets the requirement specified in chapter 441A of NAC.	-					
	This Regulation is not met as evidenced by: Surveyor: 25375 NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120). 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility. 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or						

PRINTED: 01/13/2010

FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX** CARSON CITY, NV 89701 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 216 Continued From page 7 D 216 (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sooner. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest

radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least

annually for the presence or absence of

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX** CARSON CITY, NV 89701 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 216 Continued From page 8 D 216 symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation. the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis. 5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease

in accordance with the recommendations of the Centers for Disease Control and Prevention for

PRINTED: 01/13/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 216 Continued From page 9 D 216 the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines

of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person 's medical record. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) Based on record review on 12/30/09, the facility did not ensure that 2 of 15 residents met the requirements of NAC 441A.380 concerning tuberculosis (Client #5 and #14). This is a repeat deficiency from the State Licensure survey conducted on 7/23/08. Severity: 2 Scope: 3 D 229 D 229 NAC 449.144(1)(d) Medication SS=F The policies must require that: (d) The self-administration of prescription medication be observed by a staff member who

has been oriented to the program's policies and procedures on self-administration of prescription

medication.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
NVN2ADA				B. WING	· · · · · · · · · · · · · · · · · · ·	12/30/2009			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE				
COMMUNITY COUNSELING CTR DETOX		DETOX		900 EAST LONG STREET CARSON CITY, NV 89701					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE		
D 229	Continued From page	e 10		D 229					
	Surveyor: 25375 Based on record reviet 12/30/09, the facility f distributing over-the-comultivitamins, acetam	ailed to follow it's policy counter medications su- ninophen, ibuprofen and dient who requested it obysician. ency from the State ucted on 7/23/08.	y by ch as						
D 250 SS=I	NAC 449.147(6)(a-d)	Dietary Services		D 250					
33-1	chapter 446 of NRS apursuant thereto; (b) Obtain the necess of Health Protection Side Division; (c) Maintain a report of concerning the sanital 1 year after the date of (d) Maintain a report of taken to address a definition of the sanital statement of the sanital stateme	oplicable provisions of and the regulations ado arry permits from the B Services of the Health of each inspection tion of the facility for at of the inspection; and of each corrective action of the facility for at least 1 years on (c) for at least 1 years.	ureau : least on ort						
	Surveyor: 21044 Based on observation failed to comply with 6	ot met as evidenced by n on 12/30/09, the facili chapter 446 of NRS an l establishment permit.	ty d						

PRINTED: 01/13/2010

FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 250 D 250 Continued From page 11 Findings include: The following deficiencies were identified: - None of the staff responsible for food preparation and food service were food safety certified. -A domestic dishwasher and two compartment sink were being used to clean and sanitize soiled dishware instead of a commercial dishwasher or a three compartment sink. This was a repeat deficiency from an earlier food safety inspection dated 12/9/08. - Improper labeling and dating was observed within the front dry storage room refrigerator. - Food thermometers were not being used to monitor the temperatures of prepared foods. This was a repeat deficiency from an earlier food safety inspection dated 12/9/08. - Hair restraints were not being used by staff serving food. - Single service containers were observed being used to store food. - Soiled mops were observed in buckets of dirty water and in the floor sink. Two food safety inspections were conducted on 12/9/08 and 7/7/09. During both inspections, facility staff were informed that a food establishment permit was required. The facility has yet to submit an application and pay the appropriate fee for the permit. Severity: 3 Scope: 3 **DK999 DK999 Final Comments** SS=C

PRINTED: 01/13/2010

FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) **DK999** Continued From page 12 **DK999** This Regulation is not met as evidenced by: Surveyor: 25375 NRS 652.060 "Medical laboratory" defined. " Medical laboratory " means any facility for microbiological, serological, immunohematological (blood banking), cytological, histological, chemical, hematological, biophysical, toxicological, or other methods of examination of tissues, secretions or excretions of the human body. The term does not include a forensic laboratory operated by a law enforcement agency. NRS 652.080 License required; term; renewal; inactive status; licensure of laboratory located outside state. 1. Except as otherwise provided in NRS 652.217 and NRS 652.235, no person may operate. conduct, issue a report from or maintain a medical laboratory without first obtaining a license to do so issued by the Health Division pursuant to the provisions of this chapter. 2. A license issued pursuant to the provisions of subsection 1 is valid for 24 months and is renewable biennially on or before the date of its expiration. 3. No license may be issued to a laboratory which does not have a laboratory director. 4. A license may be placed in an inactive status upon the approval of the Health Division and the payment of current fees. 5. The Health Division may require a laboratory that is located outside of this state to be licensed in accordance with the provisions of this chapter before the laboratory may examine any specimens collected within this state if the Health Division determines that the licensure is necessary to protect the public health, safety and

welfare of the residents of this state.

Based on interviews on 12/30/09, the facility did

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ **NVN2ADA** 12/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 EAST LONG STREET **COMMUNITY COUNSELING CTR DETOX CARSON CITY, NV 89701** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) **DK999** Continued From page 13 **DK999** not have a State license to conduct urinalysis screenings on non-drug court clients. Severity: 1 Scope: 3